

# Delete Family Member



- Submit this form *within 30 days* of the qualifying event (or sooner) to Benefits and Retirement Operations, Exchange Building EXC-ES-0300, 821 Second Ave., Seattle 98104-1598, or fax it to 206-684-1925.
- You might want to delete family members from some but not all benefit coverage (for example, delete them from health coverage but not life insurance coverage, if they remain eligible). If that's the case, attach an explanation to this form. If you delete family members because you and your spouse have separated, they will not be eligible to continue their health benefits under COBRA until divorce occurs.
- You might also want to submit new county insurance, state retirement and deferred compensation beneficiary designation forms.
- Questions? Go to [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits), e-mail [kc.benefits@metrokc.gov](mailto:kc.benefits@metrokc.gov) or call 206-684-1556.

Provide information about the family member you're deleting from benefit coverage

Event prompting deletion ☐ Death ☐ Qualified Medical Child Support Order ended (attach copy)  
☐ Divorce ☐ I self-pay to cover this family member and opt not to continue  
☐ Domestic partnership ended ☐ Other (explain) \_\_\_\_\_  
☐ Child no longer dependent \_\_\_\_\_

Date event occurred \_\_\_\_\_

Family member name \_\_\_\_\_ Birth date \_\_\_\_\_

Mailing address for COBRA notification (required if deleted family member is living at a different address from yours)

Street \_\_\_\_\_ Apt No \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Provide information about the family member you're deleting from benefit coverage

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City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## Authorize your change

*This information is true, correct and complete, and amends previously submitted information. I authorize King County to make any payroll deductions or refunds resulting from my requested change. I understand the willful falsification of any information I have provided may lead to disciplinary action up to and including discharge from employment.*

Employee signature \_\_\_\_\_ Date signed \_\_\_\_\_

Printed name \_\_\_\_\_ Contact phone (\_\_\_\_\_) \_\_\_\_\_

Paid ☐ 5<sup>th</sup> and 20<sup>th</sup> ea month ☐ Every other Thursday PeopleSoft Employee ID \_\_\_\_\_

Office use only	Date received	Processed by	Audited by	Date effective
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